COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

http://www.dmas.virginia.gov

PHYSICIAN

ENROLLMENT PACKAGE

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First Health Services Corporation

Fiscal Agent for Virginia's Medical Assistance Program – Provider Enrollment Unit

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Thank you for your request to participate in the Commonwealth of Virginia's Medical Assistance Program. Requesting to become a provider does not constitute automatic acceptance into the Program. Upon receipt of your completed Enrollment Application, processing of the enrollment may take up to 15 business days. First Health is unable to accept altered agreements or agreements without a signature. Additionally, the application will be returned if any portion is filled out incorrectly and/or missing information.

Enclosed is the Virginia Department of Medical Assistance Services, Provider Enrollment Application. This application is required for initial enrollment in any of the Virginia Medical Assistance Programs including the enrollment of additional locations. Each practice location must be enrolled separately. A completed Enrollment Application must include the Enrollment Application, Address Form, Participation Agreement, and any required licensure documents. If the requested date of enrollment is more than one year in the past, supporting documentation and a claim for services rendered must be submitted with the completed Enrollment Application.

Out-of-State Enrollment in Virginia Medical Assistance Programs

A provider must be located within 50 miles of Virginia's border to be enrolled as an in-state provider. When a provider not within the 50-mile radius renders services to recipients, the provider can request enrollment for the date(s) of service only. To be reactivated in any of the Virginia Medical Assistance Programs, out-of-state providers must submit claims for services rendered and a letter requesting reinstatement to the Provider Enrollment Unit.

First Health Services Corporation (FHSC), fiscal agent for Virginia's Medical Assistance Program, administers all provider enrollment functions for Virginia Medicaid. First Health's Provider Enrollment Unit is available during the hours of 8:00 A.M. and 5:00 P.M. EST, Monday through Friday, to answer any enrollment questions you may have.

You may contact a Provider Enrollment Representative by calling:

1-888-829-5373 (In-state Toll Free)
OR
804-270-5105

Electronic copies of all Virginia Medicaid enrollment forms can be found at the Virginia Department of Medical Assistance Services website at (www.dmas.virginia.gov). **All applicants should visit the Virginia Department of Medical Assistance Services website and review the provider manuals for their specific provider type.** Completed Enrollment Applications should be mailed or faxed to First Health's Provider Enrollment Unit at the following address or fax number:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-7027 (Fax)

First Health Services Corporation

ENROLLMENT FORM INSTRUCTIONS

GENERAL INSTRUCTIONS

1. Provider Program

The Virginia Medical Assistance Program(s) for which you are requesting enrollment. Note: Medallion II is the Virginia Medicaid Health Maintenance Organization (HMO) program.

2. Requested Effective Date of Enrollment

Enter the date that you are requesting your enrollment to begin.

3. Existing Virginia Medicaid Provider Numbers

If previously enrolled, list all Virginia Medicaid provider numbers assigned.

4. Legal Business Name.

The name of the business as registered with the Internal Revenue Service. This name is used to generate and report 1099 information each year. A provider doing business under his/her own name should leave this section blank.

Individual Provider Name.

Individual providers are enrolled under the last name, first name, middle initial and professional title (e.g., M.D.). This name is used to generate claim payments and report 1099 information.

5. License/Certification Number

The license number stated on your medical license from the **Virginia Department of Health Professions**. **Out-of-state providers must attach a legible copy of their licensure to the completed Enrollment Application.** If you have multiple licenses to report, please attach a separate sheet.

6. Specialty Codes

The primary specialty is first. Enter the date you were certified for your specialty. If you are certified in more than two specialties attach an additional sheet indicating the specialty and the effective dates. If you are a physician and you have a specialty, but do not include it on your Medicaid application, you will not be reimbursed for services that require a specialty certification for payment.

7. FDA Mammography Certification.

Enter your FDA Mammography Certification number. Enter the original issuance and expiration dates. You must include a legible copy of your FDA Mammography Certification with this application.

8. UPIN Number.

Enter your six (6) digit Medicare Universal Provider Identifier Number or your UPIN on this line, if available. **Enter the unique UPIN for the enrolled provider and not the same number for each provider in a practice.**

9. DEA Number.

Enter your Drug Enforcement Agency number. If applicable, attach a legible copy of your DEA license to the Enrollment Application.

10. IRS Name

Enter your IRS Name as it is registered with the IRS.

11. Social Security Number

The Social Security Number (SSN) of the individual provider if the provider is not personally incorporated under an Employee Identification Number (EIN). This is mandatory per Section 610g(a) of the Internal Revenue Code. For identification purposes, you must furnish your social security number. Additionally, Sections 1124(a)(1) and 1124A of the Social Security Act require that you disclose your social security number to receive payment.

OR

12. Employer Tax ID Number

Enter your Employer Identification Number (EIN). This is mandatory per Section 610g(a) of the Internal Revenue Code unless you are a member of a group that bills for services you render under the group Medicaid number, or you are individually incorporated.

13. Type of Applicant

Indicate the Type of Applicant: Individual, Limited Liability Partner, Sole Proprietorship, Corporation Partnership, Group Practice, or Hospital Based Physicians Health Maintenance Organization.

14. Facility Rating

Indicate whether the Facility is Profit, Non-Profit, or Not Applicable.

15. Facility Control

Indicate the Facility Control: State, Private, Public, City, Charity, or Not Applicable.

16. Fiscal Year End

The month in which your fiscal year ends and the effective dates of the fiscal year. If there is not an End Date, leave this section blank.

17. Administrator's Name

The name of the administrator of your practice or facility.

18. Number of Beds

If you are an institution, enter the number of beds for each type.

19. CLIA Number (Laboratory Services)

To be in compliance with the Center for Medicare and Medicaid Services (CMS) Clinical Laboratory Improvement Amendments (CLIA) of 1998, all laboratory testing sites must have a CLIA certificate of waiver or certificate of registration to legally perform laboratory services rendered on or after September, 1992. If you perform laboratory services, attach a copy of the CLIA certificate of waiver or certificate of registration.

ALL FORMS MUST BE SIGNED AND DATED

First Health Services Corporation

ADDRESS FORM INSTRUCTIONS

GENERAL INSTRUCTIONS

The Address Form allows providers to indicate their Servicing Address and where they would like to receive Department of Assistance Services correspondence, payments, and remittance advice. If publications are to be sent to a billing agent, business office or any address other than the Servicing Address, the provider is responsible for obtaining the information for review and abiding by the regulations set forth in the publications.

- Provider manuals, manual updates, and memoranda may be accessed via the Department of Medical Assistance Services website at www.dmas.virginia.gov.
- The EDI Manual and updates may be accessed via the First Health Services EDI website at http://virginia.fhsc.com.

1. Servicing Address (Mandatory)

Indicate the physical location (street address) of where the provider renders services. Post office box addresses are not acceptable. Your Enrollment Application will be returned if submitted with a post office box address in this section. If you have more that one servicing location, you must submit a completed Enrollment Application for each location. If the Servicing Address is the only address provided, all Department of Medical Assistance Services correspondence, payments, and Remittance Advice will be sent to the Servicing Address.

2. Mail-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services correspondence (manual updates, memoranda, etc.) sent. A post office box address is acceptable. If this section is left blank, correspondence will be sent to the Servicing Address.

3. Pay-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services payments for services rendered sent. A post office box address is acceptable. If this section is left blank, payments will be sent to the Remittance-To Address. If there is no entry in the Remittance-To address section, payments will be sent to the Servicing Address.

4. Remittance-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services Remittance Advice sent. A post office box address is acceptable. If this section is left blank, the Remittance Advice will be sent to the Pay-To Address. If there is no entry in the Pay-To Address section, the Remittance Advice will be sent to the Mail-To address. If there is no entry in the Mail-To address section, the Remittance Advice will be sent to the Servicing Address.

For First Health's Use Only

Tracking Number_____

Provider Number_____

Base ID_____

Provider Type _____

VIRGINIA MEDICAL ASSISTANCE PROGRAM PROVIDER ENROLLMENT APPLICATION

All applicants must fill out the Enrollment Application. The attached instructions contain the details that apply to each type of provider. A signed provider Participation Agreement is also required and must be submitted with each enrollment application.

THIS FORM IS TO BE USED FOR INITIAL AND ADDITIONAL ENROLLMENTS ONLY

1. **PROVIDER PROGRAM:** ___ Medicaid ___ Medallion ___ Medallion II ___ State and Local Hospital (SLH)

   ___ Client Medical Management (CMM)

   ___ Temporary Detention Order (TDO)

   ___ Family Access to Medical Insurance Security Plan (FAMIS)

2. **REQUESTED EFFECTIVE DATE OF ENROLLMENT** _____

3. **EXISTING VIRGINIA MEDICAID PROVIDER NUMBERS** _____ _____

   _____ _____ _____

4. **LEGAL BUSINESS NAME:** _____
   (If applicable, as registered with the Internal Revenue Service)

   OR

   INDIVIDUAL NAME: _____ **SUFFIX** _____ **TITLE** _____
   (Name of the provider who performs the service)

5. **LICENSE/CERTIFICATION NUMBER** _____ **LICENSING BOARD** _____

   ISSUING STATE AND ENTITY _____

6. **PRIMARY SPECIALTY** _____ **LICENSING BOARD** _____

   SECONDARY SPECIALTY _____ **LICENSING BOARD** _____

7. **FDA MAMMOGRAPHY CERTIFICATION NUMBER** _____

8. **UPIN (UNIQUE PHYSICIAN/PRACTITIONER IDENTIFICATION NUMBER)** _____

9. **DEA (DRUG ENFORCEMENT AGENCY) NUMBER FOR THIS LOCATION** _____

REMARKS:

_____

_____

_____

_____

10. IRS NAME _____

11. SOCIAL SECURITY NUMBER _____ **EFFECTIVE DATE** _____ **END DATE** _____

12. EMPLOYER TAX ID NUMBER _____ **EFFECTIVE DATE** _____ **END DATE** _____

13. TYPE OF APPLICANT (Please check one)

___ **Individual** ___ **Corporation** ___ **Hospital Based Physician** ___ **Sole Proprietorship**

___ **Group** ___ **Partnership** ___ **Health Maintenance Organization (HMO)**

___ **Limited Liability Partner**

14. FACILITY RATING (Please check one)

___ **Profit** ___ **Non-Profit** ___ **Not Applicable**

15. FACILITY CONTROL (Please check one)

___ **State** ___ **Private** ___ **Public**

___ **City** ___ **Charity** ___ **Not Applicable**

16. FISCAL YEAR END

Month _____ **Begin Date** _____ **End Date** _____

17. ADMINISTRATOR'S NAME _____

18. NUMBER OF BEDS

___ **NF** ___ **SNF-NF** ___ **SNF**

___ **ICF-MR** ___ **Non-Cert** ___ **Specialized Care**

19. CLIA NUMBER _____

SIGNATURE _____ **DATE** _____

REMARKS:

_____

_____

_____

_____

ADDRESS FORM

PROVIDER NAME _____ **TAX ID NUMBER** _____

SERVICING ADDRESS (Physical location where provider renders services)

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

CORRESPONDENCE ADDRESS (This address will be used to send forms, memoranda, etc.)

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

PAY TO ADDRESS

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

REMITTANCE ADVICE ADDRESS

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

SIGNATURE _____ **DATE** _____

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Medical Assistance Program

Participation Agreement

This is to certify:

Provider Name _____ Medicaid Provider Number _____

on this _____ day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. **The provider is authorized to practice under the laws of the state in which he is licensed and practicing and is not as a matter of state or federal law disqualified from participating in the Program.**
2. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of l973 29 USC.794) VMAP.**
3. **The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and federal personnel will be permitted upon reasonable request.**
4. **The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.**
5. **Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited.**
6. **The provider agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.**
7. **Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.**
8. **The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended. The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the protection of confidentiality and integrity of VMAP information.**
9. **This agreement may be terminated at will on thirty days' written notice by either party or by VMAP when the provider is no longer eligible to participate in the Program.**
10. **All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**
11. **This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.**

For First Health's use *only*
Director, Division of Program Operations Date

Original Signature of Provider **Date**

First Health Services Corporation

MAILING SUSPENSION REQUEST

SIGNATURE WAIVER

PHARMACY POINT-OF-SALE

Please review and check the blocks, which pertain to you:

- ☐ **MAILING SUSPENSION REQUEST:**
  I do not wish to receive Medicaid correspondence under the Medicaid provider number given below.
- ☐ **SIGNATURE WAIVER:**
  I certify that I have authorized submission of claims to Virginia Medicaid, which contain my typed, computer generated, or stamped signature.
- ☐ **PHARMACY POINT-OF-SALE AUTHORIZATION (in-state providers only):**
  I wish to submit Point-of-Sale billings to Virginia Medicaid.

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

PROVIDER NAME: _____

PROVIDER NUMBER: _____ Leave blank, if number pending.

SIGNATURE: _____

DATE: _____

TELEPHONE # _____

Please return the completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-7027 (Fax)

First Health
Services Corporation

REQUEST FOR TITLE XVIII (MEDICARE) INFORMATION

Medicare crossover payment information is an exchange of claim information between Medicare and Medicaid. If the Medicaid enrollee has Medicare as their Primary/Secondary carrier, the Medicare information is transferred to Medicaid for remaining payment, thus eliminating the need for claim submission. First Health Services is requesting information from you to automate the payment of claims paid by Medicare for Recipients that are also eligible under the Virginia Medical Assistance Program. Please indicate your Medicare number, if you have been assigned one, by your Medicare intermediary. You will not be reimbursed for Medicare crossover claims unless you supply this number. The Medicare number you indicate below will be the number that Medicaid will use to reimburse you for Medicare crossover claims. Please allow 30 days for processing of the Medicare Information Form and commencement of automated Medicare crossover.

PROVIDER NAME _____

MEDICAID PROVIDER NUMBER _____
LEAVE BLANK, IF NUMBER PENDING

MEDICARE CARRIER _____

MEDICARE PROVIDER NUMBER _____

TELEPHONE #_____

SIGNATURE_____ **DATE** _____

Please return the completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-7027 (Fax)

First Health
Services Corporation

ELECTRONIC FUNDS TRANSFER

Would you like your Medicaid and FAMIS checks to be automatically deposited in the account of your choice? If you want to participate in the Electronic Funds Transfer (EFT) program, just complete the enclosed form, tape a voided check to the form and mail or fax it to First Health at the address given below.

The start-up of EFT for a provider includes a two-week test period in which the banking institution and First Health tests the accuracy of the transfer of funds to a provider's bank account and the resolution of any detected errors. There is not a disruption in the routine disbursement of Medicaid claim payments as a paper check is generated with the provider's Remittance Advice during the test period. Upon completion of testing, the weekly deposit of funds takes place on the first business day after the Remittance date, which is typically a Monday.

The First Health Services, EFT Enrollment Representative will track the enrollment of all providers in EFT and will monitor the process each week to detect problems that may arise.

Please keep in mind the following when enrolling for EFT:

- Submit an **original** signature.
- Submit one form for each provider number.
- **All** payments for the provider number must go to the same account.
- Processing time will be a minimum of 30 days from receipt of the completed form.

First Health
VMAP-PEU
PO Box 26803
Richmond, VA 23261-6803

804-270-7027 (Fax)

First Health Services Corporation

Electronic Funds Transfer Application

GENERAL INFORMATION

Provider Name	Tax ID Number	Provider I.D. Number

Address	City	State	Zip

Authorization Agreement For Automatic Deposits (CREDITS)

I hereby authorize FIRST HEALTH **and its subsidiaries to initiate credit entries, if necessary, debit entries and adjustments for any credit in error for the following provider ID:**

Medicaid Provider ID	IRS Number

Printed Name _____ **Title** _____

Signature _____ **Date** _____

This authorization is to remain in full force until FIRST HEALTH **or the financial institution has received written notification from me and/or** FIRST HEALTH **of its cancellation in a timely manner so as to afford** FIRST HEALTH **and the financial institution a reasonable opportunity to act on it, or until the financial institution's cancellation of the agreement.**

☐ **Personal Account** ☐ **Business Account**

Place tape on this side ⟷

TAPE VOIDED CHECK HERE